TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Fondren Orthopedic Group

Respondent Name
University Of Texas System

MFDR Tracking Number
M4-14-3600-01

Carrier's Austin Representative
Box Number 46

MFDR Date Received
August 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "please review the enclosed supportive documentation and reconsider these charges for the correct allowable payment."

Amount in Dispute: $23.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional recommendation is being made because services were paid correctly per Texas Fee Schedule, locality 99."

Response Submitted by: Injury Management Organization, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2014	29806, 29826	$23.51	$23.51

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - W1 – Workers Compensation Jurisdictional Fee Schedule Adjustment
   - 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- B13 – Previously paid.

Issues

1. Is the carrier's reduction code supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier reduced the service in dispute as 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Review of the claim profile for the injured worker in TC Comp www.tdi.state.tx finds the start date of the Injury Management Organization to be 12/8/2014. The date of service in this dispute is January 23, 2014, prior to the start date of the HMO. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code 134.203 (c) states,

> To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service conversion factor).

The services in dispute will be calculated as follows;

- Procedure code 29806, service date January 23, 2014. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 15.14 multiplied by the geographic practice cost index (GPCI) for work of 1 is 15.14. The practice expense (PE) RVU of 12.34 multiplied by the PE GPCI of 0.916 is 11.30344. The malpractice RVU of 2.85 multiplied by the malpractice GPCI of 0.816 is 2.3256. The sum of 28.76904 is multiplied by the Division conversion factor of $69.98 for a MAR of $2,013.26.
- Per Medicare policy, procedure code 29823, service date January 23, 2014, may not be reported with the procedure code for another service billed on this same claim.
- Procedure code 29826, service date January 23, 2014. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3. The practice expense (PE) RVU of 1.51 multiplied by the PE GPCI of 0.916 is 1.38316. The malpractice RVU of 0.56 multiplied by the malpractice GPCI of 0.816 is 0.45696. The sum of 4.84012 is multiplied by the Division conversion factor of $69.98 for a MAR of $338.71.

3. The total allowable reimbursement for the services in dispute is $2,351.97. This amount less the amount previously paid by the insurance carrier of $2,328.46 leaves an amount due to the requestor of $23.51. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $23.51.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $23.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.